CLINICAL
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FEEDBACK FORM

MEDICAL-IN-CONFIDENCE

DATE OF FORM COMPLETION _____/_____/20_____

CLIENT AND REFERRER DETAILS

Patient name:	**Patient Date of Birth:** _____/_____/_____
Referrer Name:	**Referrer Phone Number:**
Referrer Email Address:	**Medico-legal Assessment Date:** _____/_____/20_____
Medico-legal Assessor Name:	**Medical Specialty:**
Is feedback initiated by the patient or the referrer? - **If feedback is initiated by the patient, when was feedback initially received?** _____/_____/20_____ - **Who was feedback provided to?**	**Location of assessment:**

NATURE OF FEEDBACK

1. **Is all information that has been received by the referrer, as provided by the patient, been provided to us for perusal? YES NO If no, please clarify your response.**

2. **Kindly explain the nature of the feedback in as much detail as possible. Please feel free to attach extra documentation to this response if there is insufficient space.**

FOLLOW UP

1. **Would you like us to respond to you feedback? YES NO**

   a. **If yes, what is your preferred method of communication from us with regard to handling this feedback?**
      1. **Written via email**
      2. **Phone conference**
      3. **Please contact the patient directly.**
      4. **Other (please state)** _____

WE THANK YOU FOR YOUR FEEDBACK AND WE WILL ENDEAVOUR TO INVESTIGATE AND RESOLVE ALL MATTERS REQUIRING FEEDBACK PROMPTLY AND EFFICIENTLY. WE UNDERSTAND AND ACCEPT THAT THE IME PROCESS CAN BE DIFFICULT AND CHALLENGING FOR ALL PARTIES. WE AIM TO COMMUNICATE WITH ALL KEY STAKEHOLDERS IN A TIMELY FASHION AND PROVIDE AMICABLE SOLUTIONS AT ALL TIMES.

PLEASE COMMUNICATE ANY CONCERNS REGARDING YOUR FEEDBACK TO US VIA EMAIL DIRECTLY AT IME@CLINICALEVALUATIONS.COM.AU